Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DR. PEDRO NOSNIK 4100 W. 15TH STREET STE 206 PLANO, TX 75093	MFDR Tracking #: M4-06-0010-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INDEMNITY INSURANCE CO OF NORTH BOX # 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Fee Issue carrier did not respond to billing then denied appeal."

Principal Documentation:

1. DWC 60 package
2. Medical Bill(s)
3. Medical Reports
4. Total Amount Sought $186.70

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "See attached response from Bunch & Assoc." (Respondent submitted an EOB with audit date of 11/12/04 for CPT code 95816 for date of service 10/21/04 with a paid amount of $186.70.)

Principal Documentation:

1. DWC 60 package
2. EOB

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Calculations	Amount in Dispute	Amount Due
10/21/04	95816-WP	$149.36 x 125% =$186.70	$186.70	$186.70
Total Due:				$186.70

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.202(c)(1) sets out the reimbursement guidelines for the service in dispute.

Issues

1. Did the respondent issue payment?
2. Does documentation sufficiently support that the requestor received payment?

Findings

1. The respondent provided a copy of an explanation of benefits (EOB) with an audit date 11/12/2004 which referenced the services in dispute. Specifically, the EOB indicates that $186.70 was allowed for 95816-WP. The respondent provided a copy of a check numbered 03101465-3, dated 11/12/2004 in the amount of $186.70 issued to Pedro Nosnik. This documentation does not sufficiently support that the payment was received by the requestor because: (1) the address on the check is not associated with the requestor; and (2) the endorsement stamp notes "wholesale lockbox" which the requestor attests is not Dr. Nosnik's endorsement stamp. Furthermore, the respondent also provided a document titled "Affidavit of Forgery, Unauthorized Draft or Altered Item" dated September 17, 2008 in which the requestor asserts "I never received any of the proceeds thereof or benefited in any way directly or indirectly from the proceeds." The Division concludes that the respondent did not provide sufficient proof of payment to the requestor for the service in dispute.

2. 28 TAC Section §134.202(c)(1) states in part : To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. The following represents the MAR calculation for the service in dispute: $149.36 x 125% =$186.70

Conclusion

The Division concludes that the requestor sufficiently supported non-payment of the service in dispute. As a result, the amount ordered is $186.70.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019, the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $186.70 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	3/15/2011 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).
Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.